State of Indiana

Section 125

Dependent Care Flexible Spending Account

Employee Enrollment Information Packet

PLAN YEAR: JANUARY 1, 2012 – DECEMBER 31, 2012

Key Benefit Administrators - FlexPro

P.O. Box 55210 Indianapolis, IN 46205
800-558-5553 * 317-284-7150
Fax: 866-241-1488 * 317-284-7269

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Your Online Account Has Been Made Easy

Your Flexible Benefit online account has been updated with a number of new features. If you have not already set up your online account, go to www.benefitspaymentsystem.com and set up your account today. Your online account may be used to communicate and submit information to KBA with the following tools:

- Update Your Address
- Update Your Email Address
- Submit Receipts for Flex Card Purchases
- Submit a Request for Claim Reimbursement
- Order a New Flex Card
- Review Pending Claims
- Review Claim Payment Status from Uploaded Claims
- And More…….

Please note: Many of these new features include an event-based notification that will email you once your change is made or a claim is submitted.

What is *FlexPro*?

FlexPro™ is a Flexible Benefits (Cafeteria) Plan that is approved under Section 125 of the Internal Revenue Code. It enables you to pay for certain expenses with pre-tax dollars.

Dependent Care Flexible Spending Account (FSA) — Dependent Care costs include most dependent care expenses for eligible children and adults. Qualified expenses include fees for adult and childcare centers, pre-school, and before and after school care. To be eligible you and your spouse (if married) must be employed or attend school. Your dependent must be under age 13 or physically and/or mentally incapable of caring for him or herself. As of each regular deduction date established by the Plan during a Plan Year, the Employer will credit an amount to each Participant's Plan Year Account for the corresponding amount by which the Participant's cash compensation has been reduced pursuant to his election under the Plan. Eligible claims incurred during the Plan Year and submitted within the appropriate timeframe shall be reimbursed up to the amount available in the account at the time of reimbursement. Dependent Care expenses for the care of a qualifying individual that are for the purpose of enabling the employee to be gainfully employed are eligible. Dependent Care may not be reimbursed while on Leave of Absence (LOA). *Exception for short, temporary absences.* An absence of no more than 2 consecutive calendar weeks is considered a short, temporary absence.

A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absence from work, such as for vacation or minor illness, provided that the caregiving arrangement requires the taxpayer to pay for care during the absence.

Is a Dependent Care Spending Account Right For You?

	YES	NO
Do you have Dependent Care Expenses that allow you and your spouse (if married) to be gainfully employed or attend school.	☐	☐

If you answered **YES** to this question, you can reduce the taxes that you pay by participating in your employer-sponsored Flexible Benefits Plan, ***FlexPro***, and therefore **increase your take home pay!**

What Type of Dependent Care Expenses Are Eligible?

Dependent Care FSA Expenses

Dependent Care FSA ELIGIBLE expenses include expenses necessary for you and your spouse (if married) to be gainfully employed or attend school. Eligible expenses include:

- Expenses paid for the care of a dependent under age 13
- Expenses paid for the care of a dependent who is physically or mentally incapable of caring for himself or herself
- Expenses paid to a dependent care provider
- If you are divorced your child must be in your custody for at least six months out of the year

The following list illustrates some of the Dependent Care expenses that are NOT ELIGIBLE under the Plan:

- Kindergarten
- Field trips, lunches, supplies, and transportation fees
- Overnight camps
- Care for dependent that lives outside of the employee's home
- Registration fees

Note: An individual who is gainfully employed is not required to allocate expenses during short, temporary absences from work, such as for vacation or minor illness, when the care-giving arrangement requires the employee to pay for care during the absence. An absence of up to two consecutive calendar weeks is treated as a short, temporary absence.

State of Indiana - 580

Dependent Care Flexible Spending Account Plan Specifics

PLAN YEAR:	**01/01/2012 - 12/31/2012**
Plan Options:	**Plan Maximums:**
Dependent Care FSA Plan Option	$ 5,000.00
Participation in the Dependent Care FSA Plan Option by New Hires:	Upon eligibility
Participation After Termination in the Dependent Care FSA Plan Option:	Terminated employees will be allowed 30 days past termination of employment to incur expenses and an additional 60 days to submit expenses.
Claims Submission:	Claims may be submitted as needed because daily payouts occur for State participants.
Grace Period:	The Grace Period will allow expense incurred within the first 74 days of this Plan Year to be reimbursed from your previous Plan Year if a balance remains in that account. Claims may be incurred through the end of the Grace Period, March 15th, each plan year and submitted via the claim form no later than 90 days after the end of the Grace Period, June 15th, each plan year.
Claims Submitted After the End of the Grace Period:	Claims incurred prior to the end of the plan year and subsequent grace period must be submitted no later than 90 days after the expiration of the grace period on June 15th.
Status Change Notification Time Frame:	Status changes must be submitted within 30 days of the Qualifying Event

Customer Care Phone Support
For The State of Indiana Employees
317-284-7150 or 800-558-5553

Submission of Key Benefit – Flexpro Claims:

FAX: 317-284-7269 or 866-241-1488

Emailed to: flexpro@keybenefit.com

Mailed to: Key Benefit Administrators – FlexPro
PO Box 55210
Indianapolis, IN 46205

Dependent Care FSA Frequently Asked Questions

This packet is only a brief overview of benefits that may be eligible under Dependent Care FSA.

Who can participate in the Dependent Care FSA?

There are two eligibility requirements necessary to enroll in the Dependent Care FSA.

1. You and your spouse (if married) must be employed or attend school. Your dependent must be under age 13 or physically and/or mentally incapable of caring for him or herself.
2. You must have met the eligibility requirements established by the State to participate in the Dependent Care FSA.

How do I sign up?

Enroll using People Soft self service by Monday following pay period in which you were hired or during open enrollment.

How do I determine how much money to allocate?

Be conservative! Only consider your known expenses. For dependent care, do not forget to consider vacations or times you will not be paying the dependent care provider. A list of eligible expenses and a worksheet are provided to help you calculate your expenses for the upcoming plan year.

Are there limits?

Yes, the maximum annual amount for the Dependent Care FSA is $5,000 ($2,500 if you are married and filing separate tax returns).

Can I change my annual allocation anytime during the Plan Year?

You may change your annual allocation if you have one of the eligible status changes as defined in your Employer's Plan. Examples of qualifying changes in status are marriage or divorce, death of a spouse or dependent, birth or adoption of a child, and change in your employment or in your spouse's employment. Status changes must be consistent with the status change event.

What happens if I do not use all of my annual allocation?

The IRS has established a "use it or lose it rule." If you do not use all of your annual allocation, you will forfeit any remaining amount. For example, if you allocate $500 and only submit $450 in expenses, you will lose the $50 (not just the taxes.) So, please be conservative when you determine your annual allocation.

Does my plan include a Grace Period?

Yes, the Grace Period allows employers to extend the deadline for participants to *incur* expenses for their Dependent Care Plan for 74 days after the end of the plan year.

What happens if I terminate my employment?

Termination from employment ends eligibility. Terminated employees will be allowed 30 days past termination of employment to incur expenses and an additional 60 days to submit expenses and no later than June 15th.

Can I sign up for the Dependent Care plan and still take the Dependent Care tax credit on my annual tax return?

The amount you pledge towards the Dependent Care account reduces the amount you can claim as a tax credit, dollar for dollar. Most employees (depending on your family income) will experience a higher tax savings on the Dependent Care FSA Plan. You should consult with your accountant to see which option works best for your situation.

How do I submit a claim for reimbursement?

For Dependent Care FSA expenses, send a signed claim form along with copies of statements or receipts, which show the day care provider's name, the dates of service, the amount of the service and the dependent's name to Key Benefit Administratoris - FlexPro™. Reimbursement of expenses incurred during the Plan Year shall not exceed the balance of your Plan Year Account at the time of the reimbursement.

Claim forms, including detailed receipts/invoices, may be sent for processing:
Fax to: (317) 284-7269 or (866) 241-1488
Email to: flexpro@keybenefit.com
Mail to: Key Benefit Administrators – FlexPro
PO Box 55210
Indianapolis, IN 46205
If you have not already set up your online account, go to www.benefitspaymentsystem.com and do it today! Your request for reimbursement may be uploaded to your personal online account. Your claim(s) will then be processed. Claim forms, including detailed receipts/invoices, may be faxed for processing to (317) 284-7269 or (866) 241-1488, or e-mailed to FlexPro@keybenefit.com.

Will I receive information throughout the year telling me where I stand on my account?

Yes, you will receive periodic reports showing what has been credited to your account. You will also receive a reminder letter before your plan year ends, if you have a balance in your account. You may also access your personal account on-line at any time, at: https://www.benefitspaymentsystem.com.

Will my participation in the Flex Plan affect my Social Security?

You will not pay Social Security taxes on the money you contribute to the Flex Plan. Therefore, your future Social Security benefits may be slightly reduced. However, the tax savings you receive from this plan should be more than any reduction in your Social Security benefits.

How Flex Works and How Much Can You Save?

This illustration demonstrates how a participating employee might save $780 in taxes during the Plan Year by paying for expenses with pre-tax dollars.

Please Note: This example is for illustrative purposes only.

	Without Flex	With Flex
- Annual Income	$ 30,000	$ 30,000
- Dependent Care *Pre-Tax Expenses	$ 0,000	$ 3,000
- Remaining Income To Be Taxed	$ 30,000	$ 27,000
- Estimated Taxes (26%) FICA, Federal & State **	$ 7,800	$ 7,020
- Out-of-Pocket After-Tax Expenses	$ 3,000	$ 0,000
- Take Home Pay	$ 19,200	$ 19,980
YOUR ANNUAL TAX SAVINGS	**$ 0**	**$ 780**

Use the following worksheet to figure how much you can save by participating in a Dependent Care FSA.

I. Dependent Care Expenses

Monthly expenses $ _____

x 12 months

Total Annual Dependent Care Expenses: $ _____

Multiply by an estimated tax savings of 26% x 26%

Your Estimated Annual Tax Savings: $ _____

More take home money to pay for other expenses.

* **- Restricted to Approved FSA-Eligible Dependent Care Expenses**

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State of Indiana – 580 FLEXIBLE BENEFIT PLAN CLAIM FORM

THIS SIGNED FORM MUST ACCOMPANY EACH GROUP OF RECEIPTS SUBMITTED

Employee Name: _____ ID or SSN Number: _____

Email address: _____

Home Address: _____
Number & Street City State Zip Code

☐ Please check if new address

Daytime Phone Number: _____ Number of pages: _____

To the best of my knowledge and belief, my statement in this Request for Reimbursement is complete and true. I am claiming reimbursement only for eligible expenses with the date of service incurred by me, my spouse, or my qualified dependent(s) during the applicable plan year. I certify that these expenses have not been reimbursed by any other source, nor will any reimbursement be sought from any other source. By signing and submitting a Dependent Care Reimbursement Request, I am certifying that expenses for which I request reimbursement satisfy all dependent care guidelines. I and my spouse, where applicable, are gainfully employed or a full-time student and not on leave. In accordance with the Flex Benefit Plan, I authorize my Flexible Spending Account(s) to be reduced by the amount requested.

Employee Signature: _____ Date: _____
Signature Required

***IMPORTANT:* Your request for reimbursement may be submitted from your personal online account. This form is not required when you submit your claim from your personal online account. If you have not already set up your online account, go to www.benefitspaymentsystem.com and set up your account today.**

Medical Care Expenses:

Expenses that may be covered by your (or your spouse's) medical, dental or vision plan must first be submitted to the appropriate insurance carrier. The Explanation of Benefits (EOB) you receive from your insurance carrier may then be submitted to Key Benefit Administrators - FlexPro as a qualifying receipt towards your FSA Plan. Medical care receipts must be from an independent third party and must include the Name of the Patient, Name of the Provider, Type and date of Service or Supply provided (Names of Prescriptions are required), and the Amount of the Service or Supply. Receipts for eligible over-the-counter (OTC) drugs or medicines must include the same information but the type of Supply and the Patient's Name may be hand written on the receipt by the participant if necessary. If necessary please add additional pages.

EFFECTIVE JANUARY 1, 2011 ***The cost of Over-The-Counter medicines may not be reimbursed through a Health FSA, HRA, HSA, unless the medicine is prescribed by a Physician. Copy of prescription from Physician is required.***

Name of Patient or Dependent	Date(s) of Service	Name of Provider or Merchant	Type of Service or Supply	Medical Care Charge for each service/supply	Flex Card Purchase Substantiation
			Total		

☐ **As requested, a letter of medical necessity is included.** ☐ **A letter of medical necessity is on file.**

Dependent Care: Dependent Care receipts must include the Name of the Provider, Dates of Service, Name of the Dependent(s), Fee for Service or you may have your Dependent Care Provider complete and sign below (Original Signature required).

Date(s) of Service: (to & from)_____ Amount to be reimbursed:_____

Dependent(s) Name: _____ Dependent(s) Date of Birth: _____

Dependent Care Provider Name and Tax ID #: _____

Dependent Care Provider Signature: _____ Date: _____

Dependent Care expenses for the care of a qualifying individual that are for the purpose of enabling the employee and the spouse, when applicalbe, to be gainfully employed or a full-time student are eligible. Dependent Care may not be reimbursed while on Leave of Absence (LOA). *Exception for short, temporary absences.* An absence of no more than 2 consecutive calendar weeks is considered a short, temporary absence. A taxpayer who is gainfully employed is not required to allocate expenses during a short, temporary absence from work, such as for vacation or minor illness, provided that the caregiving arrangement requires the taxpayer to pay for care during the absence.

The following reimbursement request rules apply: Medical Care and Dependent Care expenses must be incurred within the appropriate Plan Year. See Plan Specific page for eligibility requirements. Photocopies of receipts are acceptable. Please retain a copy of all receipts for your own records. *Cancelled checks are not acceptable receipts*. This form must be signed and submitted with applicable receipts.

Key Benefit Administrators - P.O. Box 55210 - Indianapolis, IN 46205 - 800-558-5553 - Fax: 866-241-1488 - Flexpro@keybenefit.com

Dependent/Spouse Card Request Form

I. Employer Name: **State of Indiana - 580**

Employee Name:_____
(Please Print) FIRST MI LAST

Employee SSN: _____ Employee Email Address:_____

II. Please issue BPS Benefits Card® Flex Card" to the spouse/dependent(s) listed below. I understand that it is my responsibility to maintain all records necessary to substantiate the eligibility of all items/services purchased with the Flex Card by my dependent(s). Must be age 18 or older.

Name: Spouse or Dependent	Social Security Number (REQUIRED)	Date of Birth (must be 18)	Yes, order an additional debit card.	No, do not order an additional debit card.

III. I UNDERSTAND AND AGREE THAT:

I accept responsibility that all Flex Card transactions of my above-listed spouse/dependent(s) are for expenditures incurred within the Plan Year. Each time the Flex Card is presented for payment, the signed receipt will evidence that the expense has been incurred and reaffirming that it is a qualified expenditure that has not been reimbursed, nor will any reimbursement be sought from any other source. Upon request, I will immediately submit any required documentation and/or transaction detail. I understand that if the Flex Card is used for purchases other than qualified expenditures, I have violated this Agreement and my obligations under my Employer's Plan. I understand that, upon notification, I must immediately re-pay the expense to the Account and that my Flex Card(s) may be immediately suspended or revoked for such failure to comply.

_____ _____
Employee Signature Date

On-Line Account Access

Online account access is available through www.benefitspaymentsystem.com. Below is an overview of all of online features available to you.

Create Your Account

When you first log in the www.benefitspaymentsystem.com, you will be asked to create your own personal user account following a few simple steps:

- Enter your I.D. (This is usually your SSN to begin set-up, thereafter your own personal I.D.)
- Choose your own secure password
- Enter your secure personal information

Manage Your Account

After you create your account, you have access to all of the following online account management tools.

- Request a reimbursement
- View your account balances
- View your pending claims
- Order a new FlexCard
- Update your personal information, including e-mails, addresses and phone numbers
- Download Forms including a claim form
- And more….

E-Mail Alerts

If you choose, you can provide us with an e-mail address and opt in/opt out of receiving regular communications via e-mail. Many of the e-mails are event based, and will go out to the e-mail address on file in your account upon certain occurrences. For example, we will e-mail you to confirm changes made to you account, such as a new address. We will also e-mail you when claims have been submitted or tell you about your balance at certain times of the plan year. These are just a few of the e-mails that we can send to you, if you choose.

Direct Deposit Authorization Form

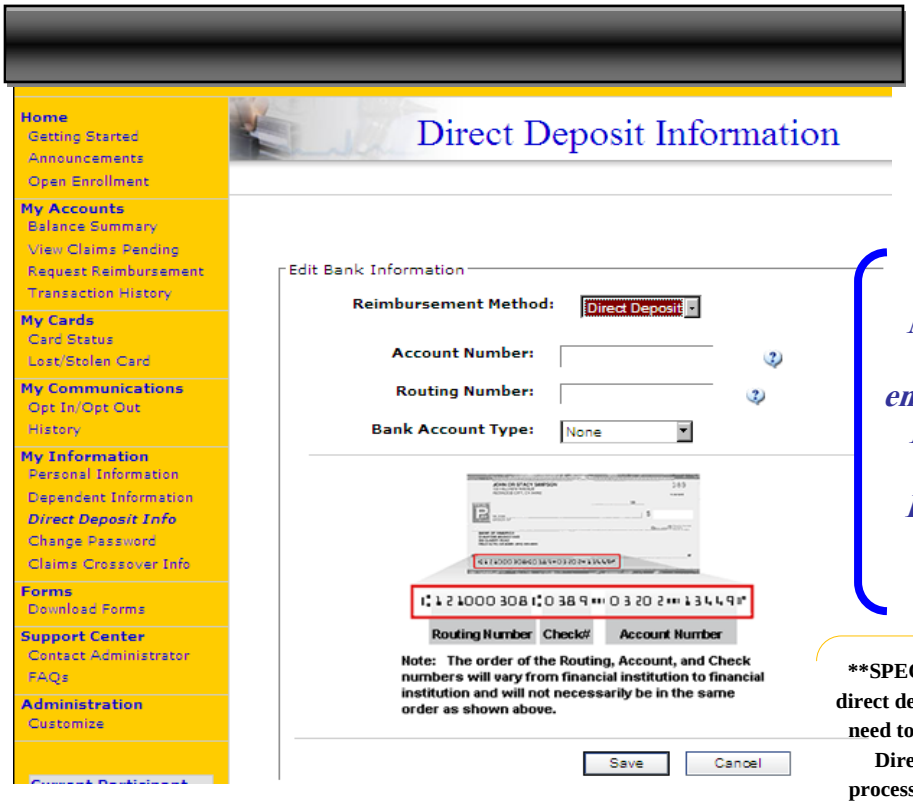
Employer: **State of Indiana - 580**			
Employee Last Name: (Please Print)	Employee First Name	Employee Middle Initial	SSN
Email Address		Daytime Phone Number ( ) -	

TWO WAYS TO CHOOSE TO SIGN UP:

Choice #1: Log on to: www.benefitspaymentsystem.com

a. Select Direct Deposit under "My Information" on the left side of the screen

b. Follow the instructions to complete your bank information



NOTE: In the event of a bank deposit rejection because the enrollee participant fails to advise KBA of a timely change in the banking account utilized for Direct Deposits, a fee of $30.00 may be assessed.

****SPECIAL NOTE:** You may update your direct deposit information online anytime. No need to submit this form if enrolling for the Direct Deposit feature online. Claims processed before the direct deposit is set up will be paid by check**

OR

Choice #2: Complete, sign and return this form

a. Account Number: _____

b. Bank Account Transit Routing Number:_____
(Use the TRN from your Checking Account, not the number on the Savings Deposit Slip)

c. Checking: _____ or Savings: _____

_____ _____
Employee Signature Date